APPLICATION FOR ANNUITY
UNDER THE RETIRED SERVICEMAN'S FAMILY PROTECTION PLAN (RSFPP) AND/OR SURVIVOR BENEFIT PLAN (SBP)

Form Approved
OMB No. 0704-0058
[redacted]

Privacy Act Statement

AUTHORITY: Chapter 73, Title 10, U.S. Code, and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: Used by eligible beneficiaries *(Widowed spouses, dependent children, surviving former spouses and natural interest persons)* to apply for an annuity.

ROUTINE USE: None.

DISCLOSURE: Voluntary; however, personal information requested on this form is used to administer certain annuity programs. Withholding requested personal information may hinder the validation process and cause difficulty in approving the requested annuity.

INSTRUCTIONS

To secure all possible benefits and to avoid delay in processing the claim:

(1) Complete the application in full;
(2) If the answer is "No" or "None," so state;
(3) Typewrite or print information in ink;
(4) Sign the application in ink or ball point pen.

SOCIAL SECURITY NUMBER

If you do not have a Social Security Number, contact the local Social Security or Internal Revenue Service Office to apply for an identifying number. If you do not know your spouse's Social Security number, or if your spouse did not have one, please submit his/her Service Number.

TRUTHFULNESS

All statements in the application must be true to the best of your knowledge, information and belief. No evidence necessary to a settlement of this claim should be suppressed or withheld. Any change in your status (financial or otherwise) should be immediately reported pursuant to instructions. Any false statement in this application or misrepresentation relative thereto is a violation of the law punishable by fine of not more than $10,000 or imprisonment of not more than 10 years or both. (52 Stat. 197, U.S.C 18:80)

SIGNATURE OF APPLICANT

When a signature is accomplished by the mark "X" or another person signs for the annuitant, due to physical inability to write on the part of the annuitant, such signatures must be witnessed by two disinterested parties.

IF YOU NEED HELP IN COMPLETING THIS FORM

CONTACT THE NEAREST MILITARY INSTALLATION, YOUR LOCAL RED CROSS CHAPTER, ANY VETERANS ORGANIZATION, OR WRITE TO THE AGENCY WHO SENT THIS FORM TO YOU.

SECTION A - DECEASED MEMBER INFORMATION

1. NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NO. (SSN)	3. DATE OF DEATH	4. DATE OF BIRTH

SECTION B - SURVIVING SPOUSE INFORMATION

1. NAME *(Last, First, Middle Initial)*	2. SSN	3. CORRESPONDENCE MAILING ADDRESS *(Street, (P O. Box), City, State, Zip Code, Country)*

4. DATE OF BIRTH	5. PLACE OF BIRTH *(City, State, Country)*

6. WERE YOU LEGALLY MARRIED TO THE DECEASED AT THE TIME OF DEATH? *(X one)*	YES		7. DATE OF MARRIAGE	8. ARE YOU A UNITED STATES CITIZEN *(X one)*	YES	
	NO				NO	

9. CURRENT BENEFITS

a. HAVE YOU APPLIED OR DO YOU INTEND TO APPLY TO THE VETERANS ADMINISTRATION (VA) FOR BENEFITS? *(X one)* — YES ☐ NO ☐
(If yes, complete 9a(1), (2), and (3) and also Section C - Affidavit on reverse side)

(1) VA CLAIM NUMBER	(2) MONTHLY AMOUNT AWARDED
	$

(3) MAILING ADDRESS OF VA OFFICE HANDLING YOUR ACCOUNT *(Street, City, State, Zip Code)*

b. ARE YOU RECEIVING ANY OTHER SURVIVOR ANNUITY OF ANY KIND ON THE RECORD OF THIS OR ANY OTHER DECEASED MILITARY MEMBER? *(If yes, complete 9b(1) and (2))* — YES ☐ NO ☐

(1) TYPE BENEFIT *(X one)*	RSFPP		SBP		(2) MONTHLY AMOUNT
					$

SECTION C - AFFIDAVIT FOR SURVIVING SPOUSE

I understand that, under the Survivor Benefit Plan (SBP), Public Law 92-425, enacted September 21, 1972:

- My annuity will be established in full if Dependency and Indemnity Compensation (DIC) or other survivor annuity payment data, as may be applicable, is not known by the service finance center at time of establishment.
- I cannot receive the full amount of both the SBP annuity and the Dependency and Indemnity Compensation that may be payable by Veterans Administration.
- I am only entitled to the amount of the SBP annuity that exceeds the DIC payments that may be payable, or the DIC only if that payment is greater than the SBP annuity.
- I cannot receive more than one SBP annuity.

If I am not now receiving DIC payments and if I later file claim for these payments, I will notify the service finance center of the amount of DIC received so that adjustment as needed may be made. I further authorize that the amount of any DIC payments received will be withheld from my SBP payments to preclude concurrent payments for the same period.

NOTE: If SBP annuity is not payable because the DIC payment is greater, all costs withheld will be refunded. If the annuity is offset by a lesser DIC payment, the cost will be recalculated and the difference between the cost withheld and the recalculated cost will be refunded.

1. SIGNATURE OF APPLICANT	2. DATE SIGNED

SECTION D - ELIGIBLE CHILDREN OF THE DECEASED *(Use additional sheet if more space is needed)*

1. NAME OF CHILD (Last, First, Middle Initial)	2. SSN	3. DATE OF BIRTH	4. AGE	5. MARITAL STATUS	6. FULL TIME STUDENT (Yes or No)	7. NAME OF CUSTODIAN (Last, First, Middle Initial)	8. ADDRESS OF CUSTODIAN (Street, City, State, Zip Code)	9. RELATIONSHIP OF CUSTODIAN TO CHILD

SECTION E - INSURABLE INTEREST PERSON OR FORMER SPOUSE

(To be completed only if you are the person designated by the deceased retired member to receive the annuity payable as a former spouse or as an individual with an insurable interest in the deceased)

1. NAME (Last, First, Middle Initial)	2. SSN	3. DATE OF BIRTH	4. CORRESPONDENCE MAILING ADDRESS (Street (P.O. Box), City, State, Zip Code, Country)

SECTION F - GUARDIAN / CUSTODIAN INFORMATION

1. HAS A GUARDIAN BEEN APPOINTED BY THE COURT FOR ANY OF THE ABOVE NAMED SURVIVORS? (X one) (If yes, complete D 3 and 4 and attach a copy of the court order) (If no, complete D 2)	YES		2. IF A GUARDIAN HAS NOT BEEN APPOINTED, WILL ONE BE APPOINTED? (X one)	YES	
	NO			NO	

3. NAME OF GUARDIAN (Last, First, Middle Initial)	4. CORRESPONDENCE MAILING ADDRESS OF GUARDIAN (Street (P.O. Box), City, State, Zip Code, Country)

SECTION G - CERTIFICATION

1. APPLICANT

a. SIGNATURE	b. DATE SIGNED	c. RELATIONSHIP TO DECEASED	d. CHECK MAILING ADDRESS (Street (P.O. Box), City, State, Zip Code, Country)

2. WITNESS

a. SIGNATURE	b. DATE SIGNED	c. MAILING ADDRESS (Street (P.O. Box), City, State, Zip Code, Country)

3. WITNESS

a. SIGNATURE	b. DATE SIGNED	c. MAILING ADDRESS (Street (P.O Box), City, State, Zip Code, Country)